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A FRAMEWORK FOR ANALYSIS OF ERISA PREEMPTION IN SUITS AGAINST HEALTH PLANS AND A CALL FOR REFORM

SUSAN O. SCHEUTZOW¹

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I. INTRODUCTION

"To Sue or Not To Sue, a Wrinkle In Federal Law Makes It Harder Than Ever To Win a Malpractice Claim" — *Newsweek*.² "HMOs Claiming Immunity Against Malpractice Suits" — *St. Louis Post Dispatch*.³ "HMOs Want To Dictate Care, Yet Avoid Malpractice Suits." — *The Sacramento Bee*.⁴ The popular press is replete with stories of the application of the preemption rules of the Employee Retirement Income Security Act of 1974 (ERISA)⁵ to managed care plans and the resulting inability of individuals covered by ERISA regulated plans to sue their managed care plans for damages caused by provider malpractice.

The public demand is growing for the courts to "level the playing field" and permit beneficiaries of ERISA regulated plans to sue their health plans for malpractice and thereby afford the same opportunities to beneficiaries of ERISA regulated health plans as are enjoyed by beneficiaries of health plans not regulated by ERISA.⁶ This controversy has also gained the attention of the federal government with the United States Department of Labor filing amicus briefs in several major preemption cases requesting that the courts permit beneficiaries under ERISA regulated health plans to sue their plans for the malpractice of plan physicians⁷ and former Labor Secretary Robert Reich speaking out in favor of the courts permitting ERISA regulated health plans to be sued for physician malpractice.⁸

This debate, however, often has focused narrowly upon the ability of beneficiaries to sue their ERISA regulated health maintenance organizations (HMOs) for malpractice or has failed to make distinctions between suits against ERISA regulated plans for the independent actions of health plans in making benefit determinations and performing utilization review and vicarious liability suits against health plans for physician malpractice. While it is possible

²Ellyn E. Spragins, *To Sue or Not to Sue?*, *NEWSWEEK*, Dec. 9, 1996, at 50.

³Robert Pear, *HMOs Claiming Immunity Against Malpractice Suits*, *ST. LOUIS POST-DISPATCH*, Nov. 20, 1996, at 5B.

⁴Frank H. Boehm, Editorial, *HMOs Want to Dictate Care, Yet Avoid Malpractice Suits*, *SACRAMENTO BEE*, Feb. 7, 1997, at B7.

⁵29 U.S.C. § 1001 et seq. (West 1996).

⁶See, e.g., Wendy K. Mariner, *Liability for Managed Care Decisions: The Employee Retirement Income Security Act (ERISA) and the Uneven Playing Field*, 86(6) *AM. J. PUB. HEALTH* 863-69 (1996); L. Frank Coan, Jr., Note, *You Can't Get There From Here—Questioning The Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs*, 30 *GA. L. REV.* 1023 (1996); Sylvia L. Wenger, Comment, *New York State Conference of Blue Cross & Blue Shield Plans et al. v. Travelers Insurance Company, et al.: Medical Malpractice and Enabling Regulation in States Again*, 51 *U. MIAMI L. REV.* 131 (1996).

⁷Briefs were filed by the U.S. Secretary of Labor in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3rd Cir.), cert. denied, 116 S. Ct. 564 (1995), and *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995).

⁸See Spragins, *supra* note 2.

that the courts can allow plaintiffs to bring suits for damages against ERISA regulated health plans for physician malpractice, it is extremely unlikely absent legislative change that the courts will allow plaintiffs to bring suits for damages against ERISA regulated health plans for the plans' actions in utilization review and benefit determinations. In addition, while permitting suits against health plans arguably would be a deterrent to health plans engaging in overzealous benefit denials and utilization review and would provide redress for those who are injured by health plans' actions, permitting retrospective lawsuits is not sufficient to provide truly effective remedies. Since benefit denials and utilization decisions often result in the denial of coverage for life-saving treatment, the desired outcome in most of these cases is for the beneficiary to receive payment for the health care treatment in question so the treatment may be obtained. While multi-million dollar judgments make headlines, the parties involved undoubtedly would have preferred that payment for the treatment had been available and that the treatment had been obtained and the life of the loved one saved.

In addition to health plan beneficiaries needing an effective method to compel benefits, also needed by those seeking medical care is an understanding of the incentives at work for providers making health care decisions so patients can factor in such incentives in making informed decisions about their own health care. Many health plans are designed to provide economic incentives or disincentives to encourage providers to make decisions regarding medical treatment which reduce the health plans' costs. Beneficiaries need this information to make informed health care decisions and to know when to seek benefits from a health plan.

This article provides a framework for an analysis of ERISA preemption of suits against health plans.⁹ The types of decisions made by health plans will be categorized and ERISA preemption concepts applied to this categorization to determine the points of inequity between ERISA regulated health plans and non-ERISA regulated health plans. This article will then review the problems inherent in relying upon the malpractice area as the primary remedy for beneficiaries seeking care under ERISA regulated and non-ERISA regulated plans and identify a number of key points for reform.

II. OVERVIEW OF RISK AND THE STRUCTURE OF HEALTH PLANS

Fundamental to understanding the ERISA preemption debate is the issue of risk for payment of health care expenses. Behind the myriad of names for managed care plans such as preferred provider organizations (PPOs), health maintenance organizations (HMOs), point of service plans (POS), and others, lies the entity which assumes the risk for payment of the health care costs. The

⁹The focus of this article is to provide an analytical framework for the ERISA preemption debate. It is not intended to be an exhaustive analysis of the case law in this area as there are others who have accomplished that task. See, e.g., Wenger, *supra* note 6; Terese M. Connerton, et al., *Suits by Beneficiaries Against Plans or Employers to Recover Benefits*, CA 23 ALI-ABA 207 (1996).

National Association of Insurance Commissioners (NAIC) defines a risk-bearing entity as one or more persons that contract with individuals, employers, or other groups to arrange for or provide healthcare benefits on a basis that involves the assumption of insurance risk by the risk-bearing entity.¹⁰ Simply put, which entity actually provides the funds that pay a claim, and if the amount of money allocated on a monthly basis (premium, capitation, etc.) is not sufficient to pay the claims for services, which entity is legally responsible to pay the claims? The answer is generally one of four types of entities: a self-funded employer, an insurance company licensed by a state; an HMO licensed by a state; or a government such as the federal government through the Medicare program.

The entity which assumes the risk is the entity that government regulators are most concerned about regulating, for if the risk bearing entity is insolvent, claims of individuals for the costs of health care services will be left unpaid. The risk bearing entity is the ultimate payer of health care claims and is referred to herein as the "health care payer."

Health care payers that incorporate utilization review¹¹ and other devices to manage health care services in their plan design may perform this utilization and management themselves or separate it from the risk bearing entity. At times, the payer actually makes benefit determinations, provides the utilization review, and other management of care or the payer may purchase these services from another entity. Different types of payers may ultimately be bearing the risk yet offer plans which look and function alike. For example, both an insurance company and a self-funded employer may contract with the same preferred provider network and offer an identical PPO plan. Similarly, a self-funded employer may purchase the same HMO coverage that a non-self funded employer chooses for its employees. Identifying the ultimate payer may become particularly confusing because at times a self-funded employer may contract with a licensed insurance company whereby the insurance company supplies a provider panel, performs utilization services, and performs certain third party administration.¹² A beneficiary may actually hold an insurance card, and for almost all purposes, the beneficiary and provider feel the "coverage" is by an insured plan, however, the ultimate payer is a self-funded employer.

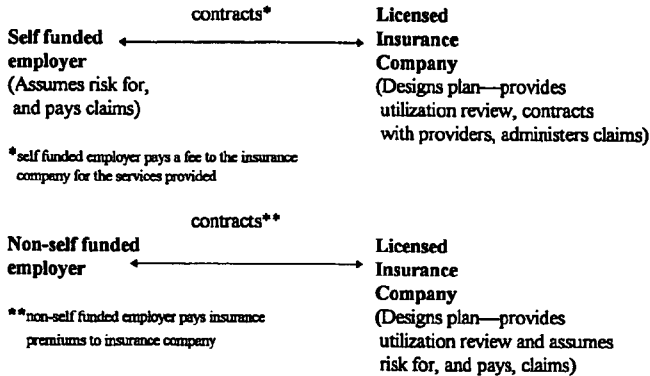
The following examples show three different managed care structures and their possible contractual relationships to self funded and non-self funded employers.

¹⁰National Association of Insurance Commissioners, Draft Paper on *The Regulation of Risk Bearing Entities*, 1996, p1 n.3.

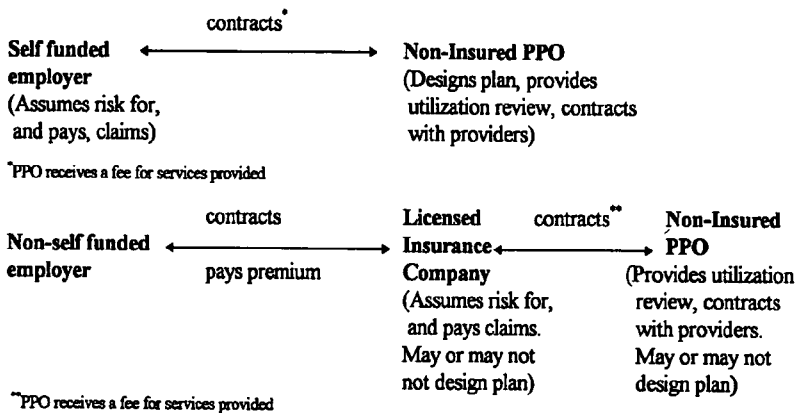
¹¹See *infra* Section IIA2.

¹²For a discussion of the structure of managed care plans, See Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 AM. J.L. & MED. 301 (1996).

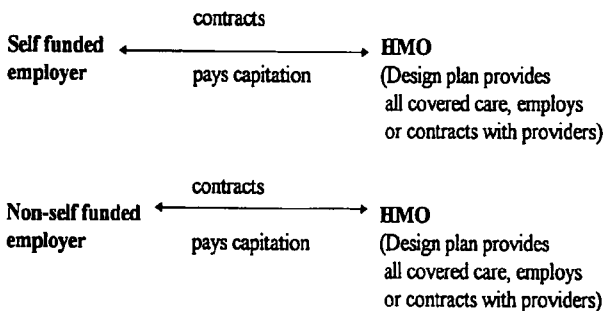
1. Insurance Company Functions as Managed Care Plan



2. Non-Insured Preferred Provider Organization Functions as Managed Care Plan



3. Health Maintenance Organizations



With any of these examples, employees of both self funded and non-self funded employers may be enrolled in identical health plans although the plans provided by the self funded employer are regulated by ERISA and the plans of the non-self funded employer are not.¹³

III. "MANAGEMENT OF CARE" AND TYPES OF MANAGED CARE LIABILITY

A. Management of Care

Concomitant with the rise of managed care in the delivery of health care, has come a proliferation of types of managed care decisions. With the third party health care coverage of yesteryear, patients generally obtained treatment and a determination was made on a "retrospective basis" as to whether the treatment was covered. Few plans had requirements for pre-approval prior to receipt of benefits and it is doubtful whether some plans even had a mechanism for making such a determination if asked. If a patient did not seek treatment due to cost considerations she did so because it was clear from the description of benefits that coverage was not provided or she made her own determination that coverage did not exist under the plan.

The types of decisions made on a retrospective basis were generally limited to whether benefits were available for a particular service and whether the service desired was "medically necessary." Some benefit determinations were simple, e.g., family planning services and "well baby" visits were covered; and others were open to interpretation, e.g., if investigational treatments were not covered, it was a particular desired treatment investigation. Medical necessity determinations usually focused on whether the treatment was necessary at all for a medical reason such as whether plastic surgery requested was purely cosmetic or was required due to an injury. Seldom did medical necessity determinations address the question of whether a particular treatment modality was the most appropriate for a particular illness or injury.

If a physician ordered treatment and the patient received treatment but the health plan later determined, on a retrospective basis, that the treatment was not covered, the patient could challenge such a determination but if unsuccessful, the patient would be responsible for the payment. Key to this system, however, was that the patient usually received the care sought when there was an ambiguity under the plan and payment issues were addressed later.

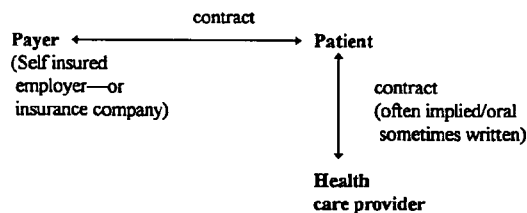
The extraordinary technological advances in medicine and the development of managed care have profoundly changed this primarily retrospective system of coverage determinations. Central to most managed care systems is the use of utilization review which involves the plan making determinations before care is rendered as to what type of service and length of treatments are necessary as well as determinations as to the most appropriate provider to render the services. For almost all significant treatments except in emergencies,

¹³See *infra* Section III.

the plan must "pre-approve" the care. If the plan does not approve the care, the patient must provide alternate payment if the care is to be received. As one court has clearly noted, "by its very nature a system of prospective decision making influences the beneficiary's choice among treatment options to a far greater degree than does the theoretical risk of disallowance of a claim facing a beneficiary in a retrospective system."¹⁴

For example, a typical utilization decision made today by a managed care plan is whether a particular mental health patient needs intensive psychotherapy or whether drug treatment will suffice. If the plan determines in its utilization review process that drug therapy is appropriate and the plan will not pay for psychotherapy, the patient may forego expensive psychotherapy if s/he must personally pay for the services. Another example of a managed care utilization decision is a determination by the plan that a particular procedure should be performed on an outpatient basis instead of an inpatient basis. Thus, the patient will generally have the surgery performed on an outpatient basis if the patient knows s/he would have to pay the costs of inpatient hospitalization.

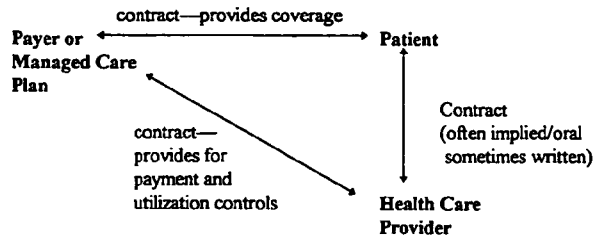
To carry out most managed care decisions, the health plan's authority to make such decisions must be written into the plan design and therefore into the health plan's contractual relationship with the patient. However, in order to fully regulate the health care providers providing services under the plan, the managed care plan must also have some direct control over the health care provider. The plan accomplishes this by having an independent contractual relationship with the provider. With the standard indemnity plans of years past, the patient had the sole contractual relationship with the provider and the patient then had an independent relationship with his or her insurance company or self-insured employer which provided what services would be paid by such insurance company or employer. The contractual relationship of a standard indemnity plan may be graphically depicted as follows:



Today, this relationship has vastly changed for now the provider has an independent relationship with the payer (or if the payer doesn't provide its own management services, with the managed care plan with which the payer contracts). This contract may provide, among other things, that the payer or managed care plan will provide utilization review and the provider will abide by such review. This contract may also provide significant other restrictions,

¹⁴Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47-48 (1987).

such as requirements that providers only refer patients to certain other approved providers¹⁵ and may offer significant financial disincentives or incentives to try to reduce the amount of referrals made to specialists or to reduce the amount of certain tests or treatments which are ordered.¹⁶ Key to enforcing these provisions is the crucial contractual relationship between the payer or managed care plan and provider.



The contract between the payer or managed care plan and provider will specify how the health care provider is to be paid and may specify that if the provider continually violates the referral or utilization restrictions of the plan, then the provider will be dropped from participation in the plan. Seldom does the patient know that his or her health care provider has a contractual relationship with the managed care plan nor does the patient know what is contained in the plan's contract with the provider, although its terms may have a significant impact upon how the health care provider renders care. Not only will patients often not know of the terms of the contracts between the payers and healthcare providers, the contract might prohibit the healthcare provider from sharing this information with the patient. These prohibitions have become known in the industry as "gag provisions."

B. Types of Managed Care Liability

In making benefit determinations and performing utilization review, the potential liability of payers and managed care plans today can generally flow from four broad categories: 1) benefit determinations; 2) utilization review; 3) liability for provider malpractice due to the managed care plan's independent negligence in provider selection and regulation including incentive systems

¹⁵A typical contractual provision of a managed care plan requires all referrals made by the physician of a patient covered by the plan to another physician be made only to other physicians under contract with the health plan. This requirement is to be followed regardless of the referring physician's medical judgment as to where a referral must be made. See, e.g., GEORGE ANDERS, *HEALTH AGAINST WEALTH*, Chapter 5, *Turning Doctors Into Gatekeepers* (1996).

¹⁶Some plans provide that primary care physicians lose compensation each specific time a referral to a specialist is made. Other plans set up "risk pools" of set-aside funds out of which funds specialists are paid and if there are funds remaining after a certain period of time, the physicians who were responsible for keeping the referral rates down receive part of the funds. Some other plans provide other types of direct or indirect financial incentives.

designed to induce providers to reduce care; and 4) strict vicarious liability for provider malpractice. The lines between the different types of liability are not always precisely drawn, but are useful to review the different types of liability.

1. Benefit Determination

Health care plans regularly make decisions as to whether a particular treatment is covered under the contractual provisions of the plan. A variety of decisions are made in the benefit determination area including decisions as to medical necessity, whether certain benefits are covered at all, and whether treatment falls under investigational exclusions. When insured plans have erroneously refused benefits and a beneficiary has been injured by not receiving such care that should have been covered, plans have been held liable for such determinations.

The most notable of plan liability cases is *Fox v. Health Net of California*.¹⁷ In this case Mrs. Fox, an enrollee in a California HMO, was diagnosed with breast cancer. She underwent two radical mastectomies and conventional chemotherapy before being approved by the University of Southern California Cancer Center as an eligible candidate for a bone marrow transplant. Health Net denied the coverage on the grounds that bone marrow transplantation was "investigational" and not proven effective in cases such as Mrs. Fox's. Mrs. Fox raised funds herself for the treatment which she ultimately received after a significant delay. Both Mrs. Fox and her husband sued Health Net for her injuries caused by the delay in treatment. Mrs. Fox died before the trial. The jury found that the delay in receiving the treatments contributed to her death and awarded the plaintiffs \$89 million in compensatory and punitive damages.¹⁸ Therefore, absent any intervening law or regulation, health plans may be held liable for damages caused by erroneous benefit determinations.

2. Utilization Review

Managed care plans are designed to accomplish what their name suggests—they are to manage the care that is rendered. This means that the plan is to determine if care is necessary at all and if so, what is the most cost effective and appropriate manner for the care to be provided to the patient. By definition the plan is to be involved in making decisions as to appropriateness of care. Most managed care plans will contend that they are not making determinations as to whether care can be obtained but are only making benefit determinations as to whether the plan will pay for the care if delivered as requested. As a practical matter, however, these determinations may be tantamount to treatment decisions if the patient will not obtain treatment for that which coverage has been denied, if providers refuse to provide the treatment unless they know that the plan has approved the treatment, or other payment is available.

¹⁷No. 21962, unreported (Riverside Cty. Cal. Super. Ct. 1993).

¹⁸This case was appealed and settled for an undisclosed amount.

Where coverage decisions once were limited to whether a plan covered a certain service and whether the services were necessary due to illness or injury, now a myriad of decisions are being made including whether the services are medically appropriate. Not only are decisions being made as to whether treatment is covered and whether the treatment is medically necessary, now decisions are being made as to which provider renders the treatment and in what setting and how much service is to be rendered, e.g., how many days of hospitalization. These decisions have a profound deleterious effect upon the amount of health services that are to be rendered and indeed costs savings are being realized, undoubtedly in part by care not being rendered.

When a plan makes a utilization decision, it can be negligent in making that decision and that negligence can be the basis for liability. This idea that entities making utilization decisions can be liable for such decisions began to gain popularity after *Wickline v. State of California*,¹⁹ in which the California Court of Appeals, while not finding liability for the reviewer, wrote the now famous dicta:

Third party payers of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost-containment mechanisms, as for example when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.²⁰

Since the door was opened over a decade ago, there has been a slow but steady movement toward finding liability for faulty utilization decisions.²¹

Note that with both benefit determinations and utilization decisions, it is the independent decisions of the managed care plan that are in question. Provider negligence does not need to be present to find the managed care plan liable and solely responsible for the injury.

¹⁹727 P.2d 753 (Cal. Ct. App. 2d Dist. Div. 5 1986), *dismissed*, 741 P.2d 613 (Cal. 1987).

²⁰*Id.* at 670.

²¹See, e.g., *Wilson v. Blue Cross of S. Cal.*, 271 Cal. Rptr. 876 (Cal. Ct. App. 2d Dist. Div. 5 1990); *Salley v. E. I. Dupont deNemours & Co.*, 966 F.2d 1011 (5th Cir. 1992); see Robert C. Macaulay, Jr., *Health Care Cost Containment and Medical Malpractice: On a Collision Course*, 19 SUFFOLK U.L. REV. 91, 106-07 (1987); David D. Griner, Note, *Paying the Piper: Third Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861, 907-11 (1991) (arguing that without liability for negligence in utilization review decisions, third party payers have incentives to control costs but not to use reasonable care in the decision making process); Laura Athens Mellas, *Adapting the Judicial Approach to Medical Malpractice Claims Against Physicians to Reflect Medicare Cost Containment Measures*, 62 U. COLO. L. REV. 287, 316 (1991) (arguing that liability will reduce possibility that poor medical decisions will be made in order to cut costs).

3. Negligent Selection, Supervision, and Plan Design

In addition to holding a managed care plan liable for its negligence in faulty utilization review or benefit determinations, arguably managed care plans should be liable for negligence in selecting providers and for ongoing regulation of physicians including compensation systems which might impact a provider's decision making.

The doctrines of negligent selection and negligent supervision have long been invoked to hold hospitals responsible for the acts of their medical staff members.²² In negligent selection cases, a party such as a hospital may be held liable for not adequately evaluating a physician initially and for permitting that physician to join the medical staff. Theoretically, the hospital has an independent duty to the patient to properly evaluate the physician, for medical staff privileges, and if the physician had been evaluated s/he would not have been able to provide services at the hospital nor been available to do the harm to the patient.

The doctrine of negligent supervision does not allege that the physician was not properly selected but holds that the hospital should have taken acts or have had systems in place which would have stopped the physician from doing whatever caused the harm to the patient and that the hospital had such a duty to the patient to have such systems in place.²³ With either of these doctrines, while there was an independent duty of the hospital to the patient, the liability of the hospital would not have arisen if the physician had not been negligent as there would have been no harm without the physician's negligence. The hospital's liability can therefore be characterized as *dependent* liability, because although it is due to the hospital's own negligence, the harm would not have been caused *but for* the provider's malpractice and the hospital's liability is dependent upon a finding of physician negligence.

With the rise in managed care plans, there has been a slow process of judicially extending the doctrine of negligent selection to the managed care context and findings that managed care plans owe a duty to their patients to solicit and retain competent physicians and when a plan fails in fulfilling that duty and the provider also malpractices, the plan can be held liable.²⁴

Similar to the duty imposed upon hospitals to appropriately supervise physicians is the growing area of potential liability for managed care plans for their role in affecting the providers' treatment decisions. Courts have begun to

²² See, e.g., *Johnson v. Mesericordia Community Hosp.*, 301 N.W. 2d 156 (Wis. 1981); *Mitchell County Hosp. Auth. v. Joiner*, 189 S.E.2d 412 (Ga. 1972); *Albain v. Flower Hosp.*, 553 N.E.2d 1038 (Ohio 1990); *Rule by Rule v. Lutheran Hosps. & Home Soc'y of Am.*, 835 F.2d 1250 (8th Cir. 1987).

²³ See generally *Martin C. McWilliams Jr. & Hamilton E. Russell, III, Hospital Liability for Torts of Independent Contractor Physicians*, 47 S.C.L. REV. 431 (1996).

²⁴ See, e.g., *McClellan v. Health Maintenance Org. of Pa.*, 604 A.2d 1053 (Pa. Super. 1992), *aff'd*, 686 A.2d 801 (Pa. 1996); *Harrell v. Total Health Care, Inc.*, No. WD 39809, 1989 WL 153066 (Mo. App. Apr. 25, 1989).

recognize that design of physician compensation arrangements might significantly affect the physician's treatment decisions and if so, the managed care plans can be held liable for the harm to the patient resulting from the physician's decisions.²⁵ In addition, plaintiffs are beginning to raise the issue as to whether there is a duty on the part of the health plan to disclose to beneficiaries financial arrangements which could affect a physician's advice.²⁶ While with negligent selection and supervision cases this issue is whether the plan should have prevented the harm, with these negligent design cases the question is whether the plan design contributed in causing the physician to malpractice.

Similar to negligent selection and supervision, liability based upon negligence in designing financial incentives is based upon the managed care plan's own actions, however, the harm would never have come to the patient but for the physician's malpractice and for that reason this liability can be characterized as dependent liability.

4. Pure Vicarious or Derivative Liability

Vicarious or derivative risk occurs when a party is held responsible for the actions of another based solely upon a relationship or an appearance of a relationship between the parties. There is no independent negligence on the part of the party held responsible. A common situation of this type happens when a physician or other individual provider allegedly commits malpractices on the premises of a hospital and the hospital is joined in the suit and found responsible for the professional's malpractice. This issue of vicarious liability also arises in a variety of other contexts, such as when healthcare is provided through a managed care entity and the provider allegedly commits malpractice and the managed care plan is joined in the suit. True vicarious or derivative liability theories, such as *respondeat superior* and agency by estoppel or apparent agency, arise when the existence of a relationship between two parties gives rise to the imposition of liability upon a party not otherwise responsible for the harm in any manner.

The doctrine of *respondeat superior* imposes legal responsibility upon an employer for the negligent acts or omissions of those acting within the scope of an employment or agency relationship. It is well settled that any employer of a health care practitioner, be it a group practice, healthcare facility, or

²⁵ See, e.g., *Pulvers v. Kaiser Found. Health Plan*, 160 Cal. Rptr. 392 (Cal. Ct. App. 2d Dist. Div. 4 1980); *Sweede v. Cigna Healthplan*, No. CIV.A.87C-SE-171-UCV, 1989 WL 12608, (Del. Super. Ct. Feb. 2, 1989); *Bush v. Doke*, No. 86-25767-NM2, unreported (Saginaw Cty. Cir. Ct. Mich. 1989).

²⁶ *Teti v. U.S. Healthcare, Inc.*, No. 88-9808, 1989 WL 143274, *aff'd*, 904 F.2d 696 (3rd Cir. 1990) (and its companion case, *Erlacher v. U.S. Healthcare, Inc.*, No. 88-9822, (E.D. Pa. 1989)). (HMO participants brought actions alleging that their HMO failed to disclose its financial incentive plan for physicians resulting in inadequate care. The case was dismissed without addressing the plan's duty to disclose financial incentives to plan participants).

managed care plan, will be responsible for the malpractice or negligence of its employed health care practitioners.²⁷

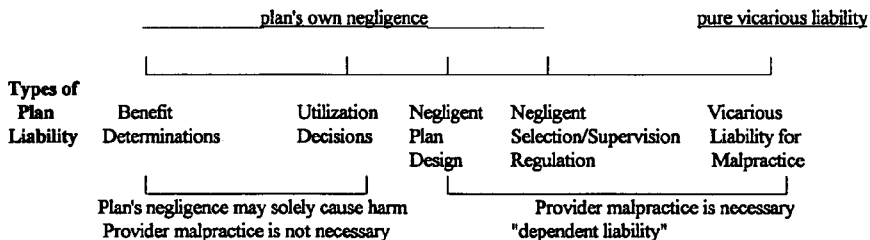
The doctrine of agency by estoppel holds an apparent principle liable for the acts of an apparent agent even if no agency or employee relationship actually exists. Although each state may differ slightly in its requirements for determining agency by estoppel, four elements are generally necessary for such a finding:

- (1) There must be a reasonable belief that an alleged agent is acting through the authority of the principal;
- (2) Such belief must be generated through the acts or omissions of the principal;
- (3) There must be justifiable reliance on the appearance of agency; and
- (4) Injury must result.²⁸

Courts have recently begun to recognize that a cause of action based upon agency by estoppel may be brought against managed care plans for the alleged malpractice of participating providers if all the necessary elements are present.²⁹

5. Continuum of Liability

The following shows the continuum of liability which may be imposed upon a managed care plan.



²⁷ See, e.g., *Klema v. St. Elizabeth's Hosp. of Youngstown*, 166 N.E.2d 765 (Ohio 1960); *Avellone v. St. John's Hosp.*, 135 N.E.2d 410 (Ohio 1956); *Davidson v. Conole*, 436 N.Y.S.2d 109, (N.Y. App. Div. 1981); *Hoffman v. Morre Regional Hosp., Inc.*, 441 S.E.2d 567 (N.C. Ct. App. 1994).

²⁸ See *McWilliams & Russell*, *supra* note 23.

²⁹ *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229 (Pa. Super. 1988); *Schleier v. Kaiser Found. Health Plan*, 876 F.2d 174 (D.C. Cir. 1989); *Dunn v. Praiss*, 606 A.2d 862 (N.J. Super. A.D. 1992), *rev'd*, 656 A.2d 413 (N.J. 1995); *but see Raglin v. HMO Ill., Inc.*, 595 N.E.2d 153 (Ill. App. Ct. 1992); and *Chase v. Independent Practice Ass'n.*, 583 N.E.2d 251 (Mass. App. Ct. 1991) (recognized the existence of vicarious liability theories applied to managed care plans but found none when the elements were not present).

IV. ERISA PREEMPTION

ERISA was adopted by Congress in 1974 to be a comprehensive regulation of employee benefit plans. ERISA carries this out by "establishing standards of conduct, responsibility and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal Courts."³⁰ ERISA does not require employers to provide benefit plans but does strictly regulate how voluntary plans may be administered. ERISA specifically regulates welfare benefit plans that provide employees with medical, surgical, or hospital care or benefits in the event of sickness, accident, disability, death, or unemployment.³¹ A plan is established when a reasonable person can ascertain the intended benefits, class of beneficiaries, the source of financing, and the procedures for receiving benefits.³² Contained in ERISA as Section 514³³ is a broad preemption clause called by at least one court as

the most sweeping federal preemption statute ever enacted: Except as provided in subsection (b) of this Section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 1003(a)(3).³⁴

If ERISA applies and the plaintiff is constrained by his or her ERISA remedies, then the problem is far greater than simply trying the case in federal court, for a claimant whose state claims are preempted by ERISA may only pursue claims in federal court and may only pursue claims for ERISA permitted remedies. ERISA Section 502 provides the exclusive civil enforcement under ERISA for plan participants and beneficiaries asserting improper processing of claims and therefore Section 502 provides the exclusive remedies which may be sought. Section 502(a)(1) provides that a plan participant or beneficiary may bring a civil action under ERISA only for the following:

- to recover benefits due him under the terms of his plan;
- to enforce his rights under the terms of his plan; or
- to clarify his right to future benefits under the terms of the plan.

In addition to Section 502(a)(1), Section 502(a)(2) permits a plan participant, a plan beneficiary, a plan fiduciary, or the Secretary of Labor to bring a civil action under ERISA³⁵ to redress violations of ERISA's fiduciary responsibility provisions. In contrast to section 502(a)(1), however, the cause of action to redress violations of a fiduciary's responsibility is not intended to vindicate

³⁰29 U.S.C. § 1001(b) (West 1996).

³¹29 U.S.C. § 1002(1)(A) (West 1996).

³²*Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982).

³³29 U.S.C. § 1144(a) (West 1996).

³⁴*California Hosp. Ass'n. v. Herring*, 569 F. Supp. 1546 (C.D. Cal. 1983), *rev'd*, 770 F.2d 856 (9th Cir. 1985), *amended*, 783 F.2d 946 (9th Cir.), *cert. denied*, 477 U.S. 904 (1986).

³⁵29 U.S.C. § 1109 (West 1996).

individual benefit rights, but rather to obtain plan-wide relief (e.g., restitution to the plan for imprudent investment losses);³⁶ and where relief sought is not on behalf of the plan, section 502(a)(2) claims will be struck.³⁷ Therefore, a beneficiary whose actions against a plan are preempted generally is left solely with an action to recover benefits.

To determine if ERISA preempts particular state claims one must turn to the interplay of state insurance law and ERISA. The McCarran-Ferguson Act³⁸ provides that the states have primary jurisdiction over the regulation of insurance. However, in enacting ERISA, Congress determined that employee benefit plans were best regulated by federal law free from state influence and enacted the sweeping preemption clause of Section 514. Following the broad preemption provision is the ERISA "savings clause" which provides that ERISA does not preempt laws which regulate insurance³⁹ and then the "deemer clause"⁴⁰ which provides that no employer benefit plan or trust covered by ERISA shall be deemed to be an insurance company.⁴¹ The application of this triad of ERISA clauses to the health care context has caused one of the most confusing scenarios of modern law. Courts have looked at each issue to determine if it "relates" to a benefit plan in which case preemption applies, or if it is an insurance issue which should be left to state regulation.

To best understand ERISA preemption in the context of managed care, the preemption decisions should be applied to the liability continuum of benefit determination, utilization review, negligent selection and regulation, and vicarious liability.

³⁶ See, e.g., *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985); *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992); *Walter v. International Ass'n of Machinists Pension Fund*, 949 F.2d 310 (10th Cir. 1991); *Simmons v. Southern Bell Tel. & Tel. Co.*, 940 F.2d 614 (11th Cir. 1991); *Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155 (3d Cir. 1990); *McMahon v. McDowell* 794 F.2d 100 (3d Cir. 1986).

³⁷ See *Watkins v. Westinghouse Hanford Co.*, 12 F.3d 1517 (9th Cir. 1993); *Tregoning v. American Community Mut. Ins. Co.*, 12 F.3d 79 (6th Cir. 1993), *cert. denied*, 511 U.S. 1082, (1994); *Anweiler v. American Elec. Power Serv. Corp.*, 3 F.3d 986 (7th Cir. 1993); *Richards v. General Motors Corp.*, 991 F.2d 1227 (6th Cir. 1993); *Horan v. Kaiser Steel Retirement Plan*, 947 F.2d 1412 (9th Cir. 1991); *Farris v. Century Planners, Ltd.*, 858 F. Supp. 150 (D. Kan. 1994); *Cairns v. Bridgestone/Firestone, Inc.*, 802 F. Supp. 152 (N.D. Ohio 1992), *aff'd*, 995 F.2d 1066 (6th Cir. 1993); *Rosile v. Aetna Life Ins. Co.*, 777 F. Supp. 862 (Kan. 1991), *aff'd*, 972 F.2d 357 (10th Cir. 1992).

³⁸ 15 U.S.C. § 1011 et seq. (West 1996).

³⁹ ERISA § 514(b)(2)(A), 29 USC § 1144(b)(2)(A) (West 1996).

⁴⁰ ERISA § 514(b)(2)(B), 29 USC § 1144(b)(2)(s) (West 1996).

⁴¹ Statutory exceptions to ERISA coverage are found at § 4(b), 29 U.S.C. § 1003(b) (West 1996), and include: governmental plans, § 3(32), 29 U.S.C. § 1002(32) (West 1996); church plans, § 3(33), 29 U.S.C. § 1002(33) (West 1996); plans maintained solely to comply with workers compensation, unemployment compensation and disability laws. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), and *District of Columbia v. Greater Wash. Bd of Trade*, 506 U.S. 125 (1992).

A. Benefit Determination

Clearly, ERISA preempts claims in which a beneficiary seeks to recover damages for improper benefit determinations. In *Pilot Life v. Dedeaux*,⁴² the United States Supreme Court reviewed a case in which a beneficiary sought damages under state tort and contract law from an insurance company that determined eligibility for an employer's long term disability plan and limited the plaintiff to his ERISA remedies. This reasoning has been applied by the Supreme Court in the health care context in *Spain v. Aetna Life Insurance Co.*⁴³ where the Court found that the health plan's determination that a bone marrow transplantation was not a covered benefit for the plaintiff's condition was preempted by ERISA.⁴⁴

This provides a profound dichotomy between ERISA regulated plans and non-ERISA regulated plans in the area of benefit determinations. Those individuals whose risk coverage is provided by insurance companies or HMOs without the involvement of a self-insured company, often can sue and recover full damages for any adverse outcomes due to erroneous and injurious benefit determinations.⁴⁵ Those individuals covered by self-funded plans, even when an HMO or insurance company administers the plan, are precluded from bringing damage suits against the self-funded employer, HMO, or insurance company for injuries sustained as a result of the HMO or insurance companies' decisions. The only recourse of latter individuals is to bring a judgment to force coverage of the health care treatment or to proceed with the treatment on a self-pay basis and later bring suit for coverage of the actual costs incurred.

This dichotomy is best shown in contrasting *Fox v. Health Net of California*⁴⁶ and *Cannon v. Group Health*.⁴⁷ In *Fox v. Health Net*, a beneficiary of an insured plan was refused an autologous bone marrow transplant for breast cancer. The delay in receiving the treatment, due to the plan's denial, was found to be a contributing factor in the patient's death and the plaintiffs were awarded an \$89 million verdict. Contrast this with *Cannon v. Group Health* where the Court of Appeals for Tenth Circuit held that ERISA preempted a claim for damages for the death of plaintiff's wife after the health plan postponed preauthorization of an autologous bone marrow transplant. The court held that the plaintiff's only remedy was to have sued for the cost of benefits but since benefits were never actually received, the plaintiff had no remedy.

⁴²481 U.S. 41, 47-48 (1987).

⁴³11 F.3d 129 (9th Cir. 1993), cert. denied, 511 U.S. 1052 (1994).

⁴⁴*Accord* Massachusetts Mut. Life Ins. v. Russell, 473 U.S. 134 (1985).

⁴⁵See *supra* Section IIIB1.

⁴⁶See Kinney, *supra* note 12.

⁴⁷77 F.3d 1270 (10th Cir.), cert. denied, 117 S. Ct. 66 (1996).

B. Utilization Review

Similar to the area of benefit determination, the courts have been quick to find ERISA preemption for health plans' utilization decisions. The case to most vividly show the effects of ERISA Section 514 preemption on self-insured managed care plans is *Corcoran v. United Healthcare, Inc.*⁴⁸ a Fifth Circuit court case. Mrs. Corcoran, a South Central Bell Telephone Company employee, became pregnant. South Central Bell had a self-insured benefit plan which provided medical benefits. The plan was administered by Blue Cross and Blue Shield of Alabama, however, the underlying risk was borne by her employer's self-funded plan. A component of the plan required all hospital admissions to obtain prior approval and continual approval was necessary to continue coverage for the hospital admission. This utilization review was performed by United Healthcare, Inc.. Mrs. Corcoran's physician recommended complete bed rest during the final months of her pregnancy, and late in the pregnancy, he ordered hospitalization so she could have round-the-clock monitoring. United Healthcare, disallowed payment for hospitalization and instead authorized ten hours a day of home nursing care. Since payment was not authorized, Mrs. Corcoran did not stay in the hospital opting instead for the home nursing care. During a period when the nurse was not on duty, Mrs. Corcoran's fetus died.

The Corcoran's sued United Healthcare and Blue Cross and Blue Shield of Alabama for wrongful death among other injuries. The defendants claimed ERISA preempted the Corcoran's claims leaving the Corcorans' solely with their ERISA remedies to recover payment of benefits. The Corcoran's claimed that Blue Cross and United Healthcare malpracticed and that such malpractice was governed by state law and could be distinguished from benefit determinations which are preempted.⁴⁹

The court refused to see the decision as solely a benefit determination, recognizing that a system of prospective decision making influences the beneficiary's choice among treatment options. However, the court found that the decision of whether the action was a benefit determination was not dispositive of the case and the question was whether the utilization decision "related to" an ERISA regulated plan. The court held that the utilization decision "related to" a self insured health plan and consequently ERISA preempted a claim for damages.⁵⁰

⁴⁸965 F.2d 1321 (5th Cir.), cert. denied, 506 U.S. 1033 (1992).

⁴⁹Some states are beginning to address whether faulty utilization review can be characterized as "malpractice" which is usually restricted to use in claims against licensed health care providers. See *Provider Network Bill Sponsors Seek Middle Ground on Solvency, Regulation*, 6(12) BNA'S HEALTH CARE DAILY, Mar. 20, 1997, at 338-340; *Medicare HMO Regulation Consistent with Arizona Decision, Vladeck Says*, 6(12) BNA HEALTH CARE DAILY, Mar. 20, 1997, at 338-340 (describing legislative proposals in New York, Alabama, and Texas).

⁵⁰See sources cited *supra* note 49. The court analyzed § 514(a) which provides that all state laws (including state law claims) that "relate to" an employee benefit plan

Cases have been quick to follow the Corcoran court's holding that ERISA preempts cases involving faulty utilization decisions. For instance, in *Kuhl v. Lincoln National Health Plan of Kansas City Inc.*⁵¹ the court held that while a health plan's refusal to certify payment for a hospital outside the service area delayed the plaintiff's heart surgery until his condition deteriorated to such an extent that a heart transplant was his only option and contributed to his death which occurred when such a transplant was not available, the utilization decision "related to" the self funded plan and the suit for damages was preempted by ERISA. Other courts have followed this reasoning as well.⁵²

In the cases involving utilization review, there may also be an issue of provider malpractice depending upon the facts of the case. Upon an independent allegation of provider malpractice, the state claim against the provider will not be preempted but the claim against the managed care plan for the utilization review will be.

C. Dependent Liability and Vicarious Liability For Provider Malpractice

The areas most active in ERISA preemption and the areas most open to rejection of the preemption doctrine are identified as dependent liability and strict vicarious liability, areas where provider malpractice is involved. This potential liability is of two distinct kinds: strict vicarious liability, and negligent selection, supervision or design cases in which an independent duty on the part of the managed care plan is alleged but provider malpractice also is present. While distinct types of liability, the cases have often raised both issues because the issues are intertwined.

Plaintiffs are beginning to look to managed care plans as possible defendants in malpractice actions on either the doctrine of strict vicarious liability or negligent selection or regulation and courts are beginning to impose liability upon non-ERISA regulated plans on the theory of negligent supervision and regulation and vicarious liability.⁵³ In the application of ERISA preemption to these cases, courts have not been consistent on the issue of whether ERISA preemption applies.

When the courts have been faced with a true vicarious liability situation, where no independent negligence on the part of the health plan is alleged, some

covered by ERISA are preempted. The court relied upon the Supreme Court's holdings that the term "relate to" is to be given its broad common sense meaning, such that a state law 'relates to' a benefit plan in the normal sense of the phrase, if has connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). See also *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992); *Ingersoll-Rand Co., v. McClendon*, 498 U.S. 133 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

51 1999 F.2d 298 (8th Cir. 1993) cert. denied, 510 U.S. 1045 (1994).

52 Accord *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Garner v. Capital Blue Cross*, 52 F.3d 314 (3th Cir.), cert. denied, 116 S. Ct. 189 (1995).

53 See *supra* Sections III (B)(3)-(B)(4).

have treated such actions as not "relating to" the benefit plan; therefore, the claims were subject to state claims and jurisdiction.⁵⁴ A number of courts have, however, held that even malpractice actions against health plans on vicarious theories are preempted⁵⁵ because the action "relates to" the plan. These cases permit the malpractice action to stand against the provider but do not permit the plan to be joined.

While clearly not yet settled and not yet addressed by the Supreme Court, lower courts seemingly move towards not finding preemption when the issue is solely the provider's malpractice and whether the managed care plan is vicariously liable.⁵⁶ Amicus briefs filed by the United States Secretary of Labor have argued vigorously for not applying ERISA preemption in this arena and recently courts have concurred that preemption is not appropriate.⁵⁷ Note, however, that true vicarious liability cases have always been difficult to prove except when a bona fide employer and employee relationship exists, and if ERISA preemption is lifted and these cases are tried in state court, the recourse provided may be more imagined than real.

When the action moves from one of pure vicarious liability into one of negligent selection or negligent supervision, the courts become much more conflicted. In two of the most recent cases, *Dukes v. U.S. Healthcare Inc.*,⁵⁸ and *Elsesser v. Hospital of Philadelphia College of Osteopathic Medicine*,⁵⁹ the courts consistently found that ERISA did not preempt allegations against a health plan for negligent selection and supervision when physician malpractice was

⁵⁴See *Prihoda v. Shpritz*, 914 F. Supp. 113 (D. Md. 1996); *Lafoy v. HMO Colo.*, 988 F.2d 97 (10th Cir. 1993); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990); *DeGenova v. Ansel*, 555 A.2d 147 (Pa. Super. Ct. 1988); *Kohn v. Delaware Valley HMO, Inc.*, No. 91-2745, 1992 WL 22241 (E.D. Pa. Feb. 5, 1992); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Chaghervand v. CareFirst*, 909 F. Supp. 304 (D. Md. 1995); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Elsessmer v. Hospital of Phila. College of Osteopathic Med.*, 802 F. Supp. 1286 (E.D. Pa. 1992); *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994).

⁵⁵*Jass v. Prudential Health Care Plan, Inc.* 88 F.3d 1482 (7th Cir. 1996); *Prudential Health Care Plan, Inc. v. Lewis*, 77 F.3d 493 (10th Cir. 1996); *Ricci v. Goberman*, 840 F. Supp. 316 (D. N.J. 1993); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D. N.Y. 1994).

⁵⁶For a full analysis of the court's reasoning in these cases see, Coan, *supra* note 6.

⁵⁷See Brief of the U.S. Secretary of Labor as Amicus Curiae in *Dukes v. United States Health Care Sys. of Pa.*, 848 F. Supp. 39 (E.D. Pa. 1994), *rev'd*, 57 F.3d 350 (3d Cir.), *cert. denied*, 116 S. Ct. 564 (1995), *Visconti v. United States Health Care*, 857 F. Supp. 1097 (E.D. Pa. 1994), *rev'd*, 57 F.3d 350 (3d Cir.), *cert. denied*, 116 S. Ct. 564 (1995), and *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); and see *Dukes*, 57 F.3d 350; and *Prudential Health Care Plan, Inc. v. Lewis*, 77 F.3d 493 (10th Cir. 1995); see, also Seema R. Shahi, Comment, *Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response To Pacificare of Oklahoma v. Burrage*, 80 MINN. L. REV. 1545 (1996).

⁵⁸57 F.3d. 350 (3rd Cir.), *cert. denied*, 116 S. Ct. 564 (1995).

⁵⁹802 F. Supp. 1286 (E.D. Pa. 1992).

present but reached their findings using different legal characterizations of the managed care company's liability. The *Dukes* court found negligent selection and supervision cases to be an attribution of direct liability on the part of the managed care plan but found preemption to be inapplicable when the issue was the quality of care rendered by the plan. The *Dukes* court therefore willingly recognized times when preemption was not absolute. The *Elsesser* court found that allegations of negligent selection and supervision to be purely vicarious liability and not subject to ERISA preemption because they did not relate to the plan.

Applying this reasoning down the continuum of liability, the *Dukes* court's reasoning does give some precedent for lifting ERISA preemption in issues of negligent plan design and perhaps even negligent utilization review cases.⁶⁰ The *Dukes* court, however, was careful to state that its holding was not to be extended to the situation of a managed care plan's utilization review decisions and should be limited solely to when the managed care plan also provides the actual care provided, such as with an HMO.⁶¹ The *Elsesser* court's reasoning clearly does not provide the courts with the ability to lift preemption in those cases where provider malpractice is not also alleged.⁶² Despite the holdings in *Dukes* and *Elsesser*, many courts have held that in negligent selection and supervision type cases in which independent negligence is alleged on the part of the managed care plan in addition to the malpractice of the physician, the liability alleged "relates to" the benefit plan and ERISA preemption applies.⁶³

However the court chooses to characterize the liability in these cases, the liability does not arise until after the provider has rendered (or failed to render) care and provider negligence has occurred. While it is very unfair to allow certain plaintiffs additional malpractice rights against an HMO or other managed care plan and others to be foreclosed, the primary action against the provider remains. The plaintiff is not usually left entirely without a defendant and the outcome of these cases determines only if another defendant can be added to the state court action. In these cases the care has either been obtained or the physician inappropriately failed to render the care and what is being

⁶⁰See, also *Dukes*, 57 F.3d 350.

⁶¹Some commentators have speculated that the loosening of preemption in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) in which the U.S. Supreme Court was willing to speculate on congressional intent in determining whether preemption applied may have the effect of eliminating preemption in suits in which physician malpractice is alleged. See F. Christopher Wethly, *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.: Vicarious Liability Malpractice Claims Against Managed Care Organizations Escaping ERISA's Grasp*, 37 B.C.L. REV. 813 (1996).

⁶²*Id.*

⁶³See *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D. N.Y. 1994) (where the court held a negligent selection claim was a wrongly administered and preempted benefit plan); *Butler v. Wu*, 853 F. Supp. 125 (D. N.J. 1994); *Altieri v. Cigna Dental Health, Inc.*, 753 F. Supp. 61 (D. Conn. 1990); *Ricci v. Gooberman*, 840 F. Supp. 316 (D. N.J. 1993).

argued about is whether the provider's decision was appropriate and whether the managed care plan had a duty to take action which would have avoided the provider malpractice. This is vastly different than the situation when the care has been denied either through a benefit determination or utilization review regardless of provider's medical judgment and the managed care plan is the only defendant.

The following graphically shows the dichotomy developed due to the application of ERISA preemption to the continuum of health plan potential liability:

	Plan liability				
	Benefit Determinations	Utilization Denials	Negligent Plan Design	Negligent Selection / Supervision	Vicarious Liability for Provider Malpractice
Non-ERISA Regulated Plans	State remedies to compel coverage or state remedies for damages	State remedies to compel coverage or state remedies for damages	State remedies to compel coverage or state remedies for damages	State remedies for damages	State remedies for damages
ERISA Regulated Plans	ERISA preempts Federal action for benefits only	ERISA preempts Federal action for benefits only	Not addressed, likely preemption applies	Split as to whether ERISA preempts. State remedies for damages may be permitted—some courts limit to ERISA remedies for benefits only.	Split as to whether ERISA preempts. State remedies for damages may be permitted—some courts limit to ERISA remedies for benefits only.

Clearly there is a dichotomy between ERISA regulated and non-ERISA regulated plans which is unfair in the types of redress permitted to injured beneficiaries under the two types of plans. This unfairness, however, is probably not going to be entirely corrected by the courts despite urging by the Department of Labor and others. The courts may determine that ERISA preemption does not apply in the area of vicarious liability for physician malpractice and perhaps in the area of negligent selection and supervision of health plan providers by managed care plans. Determinations that ERISA does not preempt these actions will allow the health plan to be joined along with the provider in suits for provider malpractice. However, even without such a determination, the injured patient is usually not left without a remedy for the suit can be brought in state court for the malpractice of the health care provider.

There is no precedent, however, for the courts to abandon ERISA preemption in the area of benefit determinations and little precedent to abandon preemption in the areas of faulty utilization review and plan design. In this area, ERISA preemption appears solid and the application of ERISA preemption leaves injured beneficiaries with no remedy. This area cries out for congressional action to permit injured beneficiaries sufficient ability to seek redress for injuries sustained by the independent actions of their health plans.

V. A CALL FOR CORRECTIVE ACTION

Clearly, lifting ERISA preemption and permitting injured beneficiaries to sue their health plans for injuries sustained due to either the health plans' independent actions or the malpractice of the health plans' providers will "level the playing field" and provide equal treatment for those enrolled in ERISA regulated plans as well as those enrolled in state-regulated insurance plans. However, equal treatment may not provide fair treatment as retrospective suits for damages are only one type of necessary remedy for beneficiaries under both ERISA regulated and non-ERISA regulated plans. While arguably large damage actions will have a deterrent effect on overzealous utilization decisions and benefit determinations, retrospective damage claims are not primarily what is needed.⁶⁴ Beneficiaries need at least the following two things to fairly obtain benefits due under a plan: first, beneficiaries need sufficient information regarding the financial incentives impacting physician decision making so that the beneficiary can make informed choices as to when to follow a physician's advice and when to seek additional care; and, second, beneficiaries need quick, effective mechanisms for challenging health plan' benefit determinations and utilization decisions. In these areas, beneficiaries under ERISA regulated plans might currently fare slightly better than beneficiaries under non-ERISA regulated plans.

A. Revealing Health Plan Financial Incentives To Patients

To date, there appears to be little to compel health plans to give beneficiaries information regarding financial incentives or contractual requirements placed upon health care providers, particularly physicians, to not make referrals, to refer to only particular providers, or to limit diagnostic procedures or treatments rendered. Patients accept physicians' advice without knowledge of any such contractual restrictions or financial incentives.

A few legislative enactments have tried to address this issue, but they have not provided for adequate disclosure. The federal government has recently begun to require managed care plans, which cover Medicare and Medicaid enrollees to give information regarding such plan incentives to enrollees, upon request, but there are no similar provisions protecting non-governmental enrollees.⁶⁵ Since many managed care plans specifically prohibit plans from providing information to patients, a number of states have passed "anti-gag" laws which prohibit contractual restrictions on a physician's ability to communicate with his or her patients.⁶⁶ These provisions prohibit a managed

⁶⁴The application of caps on damage claims advocated by "tort reform" may even vitiate any significant deterrent effect of retrospective malpractice actions.

⁶⁵61 Fed. Reg. 13430, Mar. 27, 1996.

⁶⁶Approximately thirteen states have "anti-gag" rule provisions for state regulated insurance plans. See "Anti-gag" provision appendix, page 108, Senate Interim Committee on Managed Care and Consumer Protections, Report to the 75th Texas Legislature, December, 1996.

care plan from restricting provider communications and in the case of governmental enrollees, compel disclosure upon request, however, neither compel full, complete disclosure to patients.

In a very interesting case of first impression, *Shea v. Esensten*,⁶⁷ the Eighth Circuit recently held that the fiduciary provisions of ERISA requires an ERISA regulated plan disclose to plan members any economic arrangements which would influence a healthcare provider's judgment. The plaintiffs primary care physician, who was under contract with the managed care plan, refused to make a referral to a specialist. Unknown to the patient, the physician's contract with the managed care plan provided incentives for physicians not to refer to specialists. Despite the patient's initial request for a referral to a cardiologist, the plaintiff accepted the primary care physician's advice that given the patient's age, significant cardiac problems were not likely and a referral was not necessary. The patient did not see a cardiologist and died of heart failure. The court held that ERISA fiduciaries must communicate to beneficiaries any financial incentives which discourage a treating physician from providing health care referrals.

If this case is followed by other jurisdictions, ERISA plan members will begin to receive full information regarding incentives and contractual obligations placed upon physicians. There is no similar requirement for beneficiaries of non-ERISA plans to receive similar information. This information is necessary for any beneficiary to make informed decisions and should be addressed legislatively for ERISA regulated and non-ERISA regulated plans alike.

B. Challenge To Benefit Denials and Utilization Decisions

Beneficiaries under ERISA regulated plans and non-ERISA regulated plans need quick, effective procedures to challenge benefit denials and utilization decisions. These procedures should give beneficiaries the ability to meaningfully challenge plan decisions in sufficient time so that if benefits are to be obtained, they are obtained in sufficient time to impact the beneficiaries' health. Currently some redress exists under the law but it is not adequate.

1. HMOs

Most HMOs will have a mechanism in place for resolving grievances. The NAIC model HMO act which has been adopted in whole or part by most of the states provides that HMOs must establish consumer grievance procedures.⁶⁸ These procedures maintained by the HMO may be effective, although presumably since an HMO's license to operate in a state may be dependent upon such procedures, an HMO has an interest in establishing a procedure which will not be subject to extensive criticism.

⁶⁷107 F.3d 625 (8th Cir. 1997).

⁶⁸See Kinney, *supra* note 12; Barbara Allan Shickich, *Legal Characteristics of the Health Maintenance Organization in Healthcare Facilities Law: Critical Issues for Hospitals, HMOs, and Extended Care Facilities* (Anne M. Dillinger, ed., 1991).

2. ERISA Plans

ERISA regulations require that each participant whose benefits have been denied be given a reasonable opportunity for review of the decision.⁶⁹ This review process has been criticized, however, in that the participant does not have an automatic right to a hearing and the review can be performed by the same party that originally denied the claim.⁷⁰

Since an administrative procedure exists under ERISA, the issue of exhaustion of remedies arises. Courts have generally required plaintiffs to exhaust their administrative remedies and go through the plan's grievance procedure prior to filing suit.⁷¹ At least one court has held that exhaustion is not required when the delay could result in irreparable harm to the participant.⁷² Requiring exhaustion of an inadequate administrative remedy prior to judicial review will only further harm a beneficiary whose primary interest is receiving coverage for needed services.

What beneficiaries of ERISA regulated and non-ERISA regulated plans alike need is a quick, objective method of review of benefit determinations and utilization decisions. This may be a quick recourse to the courts or an effective grievance procedure where the decision is made by a party other than the party making the initial determination.⁷³ Since by definition, however, successful challenges to benefit determinations and utilization decisions result only in payment for the services desired, beneficiaries may not have the resources to pay the costs to challenge these health plan decisions. Undoubtedly, the small number of cases judicially challenging benefit determinations and utilization decisions to date is in large part due to the lack of resources of a beneficiary to make the challenge, since even if successful, seldom will additional dollars be awarded to the beneficiary to pay the cost of such challenge.⁷⁴ Additionally, suit may not be pursued because it is determined that the time involved in pursuing the action judicially does not make suit an effective remedy. Patients in need of medical treatment and concerned about finding alternative sources

⁶⁹See *Crocco v. Xerox Corp.*, No. 5:91-CV-779, ___ F. Supp. ___, 1997 WL 73210 (D.C. Conn. Feb. 5, 1997).

⁷⁰National Association of Insurance Commissioners. NAIC White Paper, *ERISA: A Call for Reform, Recommendations of the National Association of Insurance Commissioners*, 3 (1995).

⁷¹See, e.g., *Communications Workers of Am. v. AT&T*, 40 F.3d 426 (D.C. Cir. 1994); *Amato v. Bernard*, 618 F.2d 559 (9th Cir. 1980); *Smith v. Blue Cross & Blue Shield United of Wis.*, 959 F.2d 655 (7th Cir. 1992).

⁷²*Tomczscyn v. Teamsters, Local 115 Health & Welfare Fund*, 590 F. Supp. 211 (E.D. Pa. 1984).

⁷³State legislatures are beginning to address grievance procedures to resolve disputes. See 18(12) *CRAINS CLEVELAND BUS.* 3, Mar. 24-30, 1997.

⁷⁴If the plaintiff can allege fraud or bad faith, then punitive damages may be available. However, but every adverse determination, even if found to be erroneous, does not involve bad faith or fraud.

of payment will not have the time or be willing to expend the funds for judicial challenge. Any solution to a beneficiary's need for an effective, quick resolution of benefit determinations and utilization decisions must address the cost of challenge to be a meaningful solution.

VI. CONCLUSION

The effect of ERISA preemption on suits against health plans has certainly created an unfair dichotomy between beneficiaries of ERISA regulated and non-ERISA regulated health plans in their ability to retrospectively sue for damages caused by the health plan's actions. Correcting the inequality created by ERISA preemption would eliminate this inequity in remedies between beneficiaries of the two types of plans. Full correction of this problem, however, cannot be accomplished by judicial change alone and needs congressional action.

Correcting the inequity caused by ERISA preemption, however, will still not give beneficiaries of ERISA regulated and non-ERISA regulated plans the tools they need to effectively obtain benefits due to them under their health plans. To effectively obtain benefits due, beneficiaries need information regarding the arrangements between their providers and managed care plans and they need a quick, objective, and affordable method to obtain review of health plan benefit determinations and utilization decisions.

